Commonwealth of Massachusetts
Group Insurance Commission

Return completed form to the GIC Coordinator at your City/Town Benefits Office. Do not return to the GIC

Initial Municipality Insurance Enrollment Form – Active Employees and Non-Medicare Retirees

Only valid for municipalities joining 7/1/09

01 ☐

Insured's GIC-ID (usually Soc. Sec. #)	Sex: Male ☐ Female ☐	Date of Birth	Dept. ID # or Agency/Division #
___ ___		/ /	666/

Name - Last | First | MI | Check one: ☐ Active Employee ☐ Retiree ☐ Survivor

Address | City | State | Zip Code

Name of Municipality | Home Phone ( ) | Work Phone ( )

02 ☐ **HEALTH COVERAGE** | **Effective Date: 7 / 01 / 09**

New Enrollment ☐ Decline Coverage ☐

☐ **Health** (Select one of the health plans below and individual or family coverage)

Health Plan – Active Emplyees and Non-Medicare Retirees

- ☐ Fallon Direct
- ☐ Fallon Select
- ☐ Harvard Pilgrim Independence
- ☐ Health New England
- ☐ Navigator by Tufts Health Plan
- ☐ NHP Care – Neighborhood Health Plan (HMO app required)
- ☐ UniCare State Indemnity/Basic CIC: ☐ Yes ☐ No
- ☐ UniCare/Community Choice
- ☐ UniCare/PLUS

Coverage
- ☐ **Individual**
- ☐ **Family**

SPOUSE/DEPENDENT INFORMATION

List below all family members, including your spouse, who will be covered under your health plan. Attach a seperate sheet if additional space is required. Please provide all Social Security Numbers and exact dates of birth for each dependent. Coverage for children ends at age 19; to continue their coverage you must complete and return to the GIC a Dependent Age 19 and Over Application for Coverage.
Important: The Group Insurance Commission requires you to provide a copy of a marriage certificate, birth certificate, certificate of appointment as legal guardian, etc., for each person you list as a dependent.

Last Name	First	Middle	Relationship	Date of Birth	Sex	Social Security Number

Reason for addition or deletion: _____ Effective date: _____

SPOUSE INFORMATION

Is your spouse employed? ☐ Yes ☐ No Name of employer _____ Address of employer _____

Is your spouse covered under his or her employer's group health insurance plan? ☐ Yes ☐ No Name of insurance company _____

Policy/Certificate Number _____ Address of insurance company _____

Are you and/or your children covered under your spouse's group health insurance plan? You: ☐ Yes ☐ No Children: ☐ Yes ☐ No

Is your spouse enrolled in Medicare? ☐ Yes ☐ No If yes, Medicare claim number _____

FORMER SPOUSE

Name _____ Social Security Number _____ Date of Birth _____ Date of Divorce _____
Last First Middle

Address _____
Street City State Zip Code

Is your former spouse employed? ☐ Yes ☐ No Name of employer _____

Is your former spouse covered under his or her employer's group health insurance plan? ☐ Yes ☐ No

SIGNATURE REQUIRED

x _____ x _____
Signature of Applicant Date Signature of Authorized Official Date

FOR GIC USE ONLY:	Entered	Verified	Political Subdivision